

		FOR OHF USE					

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**2001**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2001)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0016964</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>Bohannon Nursing Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2001</u> to <u>12/31/2001</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>1201 N. Alton</u> <u>Lebanon</u> <u>62254</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>St. Clair</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____	
<b>Telephone Number:</b> <u>(618)537-4401</u> <b>Fax #</b> <u>(618)537-4447</u>		(Type or Print Name) <u>Ken Bohannon</u>	
<b>IDPA ID Number:</b> <u>37-0708824-001</u>		(Title) <u>President</u>	
<b>Date of Initial License for Current Owners:</b> <u>04/06/1950</u>		(Signed) _____ (Date) _____	
<b>Type of Ownership:</b>		<b>Paid Preparer</b> (Print Name and Title) <u>Michael J. Hund, Partner</u>	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT		(Firm Name & Address) <u>Boyce, Hund &amp; Associates</u> <u>42 West Main St. Mascoutah, IL 62258</u>	
<input type="checkbox"/> Charitable Corp.		(Telephone) <u>(618)566-2341</u> <b>Fax #</b> <u>(618)566-4220</u>	
<input type="checkbox"/> Trust		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
<b>IRS Exemption Code</b> _____			
<input checked="" type="checkbox"/> PROPRIETARY			
<input type="checkbox"/> GOVERNMENTAL			
<input type="checkbox"/> Individual			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Corporation			
<input checked="" type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Michael J. Hund</u> <b>Telephone Number:</b> <u>(618)566-2341</u>			

## STATE OF ILLINOIS

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Facility Name & ID Number Bohannon Nursing Home# 0016964 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>101</u>	Skilled (SNF)	<u>101</u>	<u>36,865</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>101</u>	TOTALS	<u>101</u>	<u>36,865</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>14,845</u>	<u>10,820</u>	<u>467</u>	<u>26,132</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,845</u>	<u>10,820</u>	<u>467</u>	<u>26,132</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 70.89%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 04/12/72

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date \_\_\_\_\_ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number  
of beds certified 9 and days of care provided 467Medicare Intermediary Administar Federal

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED  
CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/2001 Fiscal Year: 12/31/2001

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number

Bohannon Nursing Home

# 0016964

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	130,136	8,512	4,746	143,394		143,394		143,394		1
2	Food Purchase		109,037		109,037		109,037	(613)	108,424		2
3	Housekeeping	87,698	10,314		98,012		98,012		98,012		3
4	Laundry	35,702	10,653		46,355		46,355		46,355		4
5	Heat and Other Utilities			58,990	58,990		58,990		58,990		5
6	Maintenance	20,656	6,363	18,686	45,705		45,705		45,705		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	274,192	144,879	82,422	501,493		501,493	(613)	500,880		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,300	3,300		3,300		3,300		9
10	Nursing and Medical Records	742,602	36,309	15,175	794,086		794,086	(11,053)	783,033		10
10a	Therapy	25,452	350	270	26,072		26,072	(6,525)	19,547		10a
11	Activities	26,360	1,721	1,138	29,219		29,219		29,219		11
12	Social Services	14,777		1,457	16,234		16,234		16,234		12
13	Nurse Aide Training	12,056	1,088	700	13,844		13,844		13,844		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	821,247	39,468	22,040	882,755		882,755	(17,578)	865,177		16
	<b>C. General Administration</b>										
17	Administrative	87,959			87,959		87,959		87,959		17
18	Directors Fees										18
19	Professional Services			62,986	62,986		62,986	(43,200)	19,786		19
20	Dues, Fees, Subscriptions & Promotions			12,743	12,743		12,743	(4,704)	8,039		20
21	Clerical & General Office Expenses	35,933	8,874	7,276	52,083		52,083	(61)	52,022		21
22	Employee Benefits & Payroll Taxes			144,123	144,123		144,123	(12,460)	131,663		22
23	Inservice Training & Education			177	177		177		177		23
24	Travel and Seminar			3,866	3,866		3,866	(1,873)	1,993		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			30,889	30,889		30,889		30,889		26
27	Other (specify):*			5,816	5,816		5,816	(5,816)			27
28	<b>TOTAL General Administration</b>	123,892	8,874	267,876	400,642		400,642	(68,114)	332,528		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,219,331	193,221	372,338	1,784,890		1,784,890	(86,305)	1,698,585		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

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Facility Name & ID Number **Bohannon Nursing Home**

#0016964

Report Period Beginning: 01/01/2001 Ending: 12/31/2001

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			88,582	88,582		88,582	(31,387)	57,195			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,073	22,073		22,073	(22,073)				32
33	Real Estate Taxes			38,318	38,318		38,318		38,318			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			6,266	6,266		6,266		6,266			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			155,239	155,239		155,239	(53,460)	101,779			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			29,733	29,733		29,733		29,733			39
40	Barber and Beauty Shops			6,312	6,312		6,312	(5,953)	359			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,297	55,297		55,297		55,297			42
43	Other (specify):*			2,905	2,905		2,905	(2,905)				43
44	<b>TOTAL Special Cost Centers</b>			94,247	94,247		94,247	(8,858)	85,389			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,219,331	193,221	621,824	2,034,376		2,034,376	(148,623)	1,885,753			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name &amp; ID Number Bohannon Nursing Home

# 0016964

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
NON-ALLOWABLE EXPENSES	Amount	Refer-	OHF USE	
		ence	ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals				4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	(31,387)	30		9
10 Interest and Other Investment Income	(22,073)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(613)	2		13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions	(212)	27		20
21 Owner or Key-Man Insurance	(3,297)	27		21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(2,905)	43		24
25 Fund Raising, Advertising and Promotional	(3,510)	20		25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule	(84,626)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (148,623)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)			34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B) )	\$ (148,623)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		X	\$		38
39					39
40 Gift and Coffee Shops		X			40
41 Barber and Beauty Shops		X			41
42 Laboratory and Radiology		X			42
43 Prescription Drugs		X			43
44 Exceptional Care Program		X			44
45 Other-Attach Schedule					45
46 Other-Attach Schedule					46
47 TOTAL (C): (sum of lines 38-46)			\$		47

**Bohannon Nursing Home**

ID# 0016964

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Beauty Shop Revenue	\$ (5,953)	40	1
2	Airplane	(2,307)	27	2
3	Non-Care Related Travel	(1,873)	24	3
4	Bank Charges	(61)	21	4
5	Subscriptions, Dues	(1,194)	20	5
6	Employee Insurance	(11,630)	22	6
7	Employee Meals	(830)	22	7
8	Patient Medical Supply Revenue	(11,053)	10	8
9	Therapy Revenue	(6,525)	10a	9
10	Marketing	(43,200)	19	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(84,626)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Bohannon Nursing Home

# 0016964

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(613)	0	0	0	0	0	0	0	0	0	0	(613)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(613)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(613)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(11,053)	0	0	0	0	0	0	0	0	0	0	(11,053)	10
10a	Therapy	(6,525)	0	0	0	0	0	0	0	0	0	0	(6,525)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(17,578)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(17,578)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(43,200)	0	0	0	0	0	0	0	0	0	0	(43,200)	19
20	Fees, Subscriptions & Promotions	(4,704)	0	0	0	0	0	0	0	0	0	0	(4,704)	20
21	Clerical & General Office Expenses	(61)	0	0	0	0	0	0	0	0	0	0	(61)	21
22	Employee Benefits & Payroll Taxes	(12,460)	0	0	0	0	0	0	0	0	0	0	(12,460)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,873)	0	0	0	0	0	0	0	0	0	0	(1,873)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(5,816)	0	0	0	0	0	0	0	0	0	0	(5,816)	27
28	<b>TOTAL General Administration</b>	<b>(68,114)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(68,114)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(86,305)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(86,305)</b>	<b>29</b>



Facility Name & ID Number Bohannon Nursing Home# 0016964Report Period Beginning: 01/01/2001 Ending: 12/31/2001

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Ken Bohannon	100.00%	None				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

## STATE OF ILLINOIS

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Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Ken Bohannon	President	Asst. Administrator	100.00	0	24	60.00	Salary	\$ 22,688	Ln 17, Col 1	1
2	Lee Bohannon-Smith	None	Administrator	0.00	0	40	100.00	Salary	65,271	Ln 17, Col 1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 87,959		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	Not Applicable								2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Small Business Administration		X	Addition Construction	\$2,813.00	11/12/86	\$ 332,000	\$ 132,261	11/12/06	0.0800	\$ 12,460	1	
2	Bank of O' Fallon		X	Refinance (Construction)	\$4,300.00	02/28/99	177,734	82,198	01/31/02	0.0800	8,662	2	
3												3	
4												4	
5												5	
	Working Capital												
6	First Insurance Funding		X	Liability Insurance	\$3,483.00	06/01/01	30,330	6,900	03/01/02	0.0800	951	6	
7												7	
8												8	
9	TOTAL Facility Related				\$10,596.00		\$ 540,064	\$ 221,359			\$ 22,073	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 540,064	\$ 221,359			\$ 22,073	15	

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Bohannon Nursing Home COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0016964

CONTACT PERSON REGARDING THIS REPORT Michael J. Hund

TELEPHONE (618) 566-2341 FAX #: (618) 566-4220

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>05-18.0-300-019</u>	<u>Facility</u>	\$ <u>35,969.00</u>	\$ <u>35,968.00</u>
2. <u>05-18.0-300-018</u>	<u>Facility</u>	\$ <u>641.00</u>	\$ <u>641.00</u>
3. <u>05-18.0-308-010</u>	<u>Vacant lot across the street</u>	\$ <u>568.00</u>	\$ _____
4. <u>05-18.0-309-001</u>	<u>Vacant lot across the street</u>	\$ <u>386.00</u>	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>37,564.00</u></u>	\$ <u><u>36,609.00</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES   X   NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,919

B. General Construction Type: Exterior Brick Frame Concrete & steel Number of Stories 1

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home	174,240	1972	\$ 10,000	1
2					2
3	TOTALS	174,240		\$ 10,000	3

Facility Name &amp; ID Number Bohannon Nursing Home

# 0016964

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	51		1972	1972	\$ 514,667	\$ 12,867	40	\$ 12,867	\$	373,134	4
5	50		1986	1986	705,125	36,395	40	17,628	(18,767)	271,767	5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9	Building Equipment		1972		67,551		10			67,551	9
10	Heating System, Air Conditioner		1978		18,296		15			18,296	10
11	Fire Alarm		1980		3,770		25			3,770	11
12	Fan System		1982		1,388		20	69	69	1,324	12
13	Roof		1983		38,993		25	1,560	1,560	29,375	13
14	Shed & Alarm		1983		7,672		20	384	384	6,948	14
15	Gas Line		1984		694		30	23	23	415	15
16	Heat Pumps		1984		11,560		15			11,560	16
17	Chart System, Windows, Doors		1984		3,847		20	192	192	3,289	17
18	Air Conditioners		1985		1,524		8			1,524	18
19	Water Heaters		1985		3,106		15			3,106	19
20	Sprinkler System		1986		39,807	2,095	25	1,592	(503)	24,548	20
21	Storage Trailer		1986		1,806		20	90	90	1,445	21
22	Water Heater, Nurse Call		1986		2,025		15	68	68	2,025	22
23	Alarm, Extinguisher, Phones		1986		859		10			859	23
24	Water Heater		1990		2,185		15	146	146	1,687	24
25	Water Heater		1991		2,034		15	136	136	1,367	25
26	Phone, Heater Unit		1992		1,799		10	180	180	1,674	26
27	Air Conditioner		1993		7,689		10	769	769	6,600	27
28	Air Conditioner		1995		2,385	239	10	238	(1)	1,470	28
29	Water Softener		1996		500	31	12	42	11	240	29
30	Front Circle Driveway		1998		8,716	662	15	581	(81)	2,130	30
31	Parking Lot, Fuel Tank		1998		21,523	1,688	20	1,076	(612)	3,334	31
32	Water Softener		1998		2,764		12	230	230	768	32
33	Heating/Cooling Unit		1999		8,685	1,534	10	869	(665)	1,873	33
34	Roof		2000		15,823	1,503	20	791	(712)	1,121	34
35	Water Heaters		2000		5,810	1,423	15	387	(1,036)	678	35
36	Portable Aspirator, Phone System		2001		3,924	3,925	10	262	(3,663)	262	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Windows		2001	\$ 7,905	\$ 99	40	\$ 33	\$ (66)	\$ 33	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70 TOTAL (lines 4 thru 69)			\$ 1,514,432	\$ 62,461		\$ 40,213	\$ (22,248)	\$ 844,173	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 97,945	\$ 14,674	\$ 16,477	\$ 1,803		\$ 219,254	71
72	Current Year Purchases	15,923	11,447	505	(10,942)		505	72
73	Fully Depreciated Assets	214,421						73
74								74
75	TOTALS	\$ 328,289	\$ 26,121	\$ 16,982	\$ (9,139)		\$ 219,759	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,852,721	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 88,582	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 57,195	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (31,387)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,063,932	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	25% Plane & Radio 1982	\$ 6,574	\$	\$ 6,574	86
87	25% Plane Engine 1988	3,394		3,394	87
88	25% Storm Scope 1986	2,347		2,347	88
89	Pickup Truck 1979	8,743		8,072	89
90					90
91	TOTALS	\$ 21,058	\$	\$ 20,387	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
- If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.  
This amount was calculated by dividing the total amount to be amortized by the length of the lease                     .

9. Option to Buy: ☐ YES ☐ NO Terms:                                     \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 6,217 Description: Copier (5203) + Computer (1014)  
(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:  
Beginning                       
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>                    </u> /2002	\$ <u>                    </u>
13.	<u>                    </u> /2003	\$ <u>                    </u>
14.	<u>                    </u> /2004	\$ <u>                    </u>

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input checked="" type="checkbox"/> YES      <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE <u>89</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE <u>40</u></p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies	260	828		1,088
3	Classroom Wages (a)				
4	Clinical Wages (b)		7,056		7,056
5	In-House Trainer Wages (c)		5,000		5,000
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		700		700
9	TOTALS	\$ 260	\$ 13,584	\$	\$ 13,844
10	SUM OF line 9, col. 1 and 2 (e)	\$ 13,844			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	14
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	5
2. From other facilities (f)	
TOTAL TRAINED	19

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	Line 39, Col 3	hrs	\$	114	\$ 6,014	\$	114	\$ 6,014	1
2	Licensed Speech and Language Development Therapist	Line 39, Col 3	hrs		19	690		19	690	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Line 39, Col 3	hrs		196	10,921		196	10,921	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Line 39, Col 3	# of prescripts				11,421		11,421	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): X-Ray	Line 39, Col 3		687					687	13
14	TOTAL			\$ 687	329	\$ 17,625	\$ 11,421	329	\$ 29,733	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 375,714	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	408,527		3
4	Supply Inventory (priced at )	9,812		4
5	Short-Term Investments			5
6	Prepaid Insurance	34,297		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	10,458		8
9	Other(specify): <u>A/R-Employees</u>	2,215		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 841,023	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	264,021		12
13	Land	10,000		13
14	Buildings, at Historical Cost	1,219,792		14
15	Leasehold Improvements, at Historical Cost	294,640		15
16	Equipment, at Historical Cost	349,347		16
17	Accumulated Depreciation (book methods)	(1,501,420)		17
18	Deferred Charges	3,887		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	29,304		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 669,571	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 1,510,594	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 17,765	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	60,258		30
31	Accrued Taxes Payable (excluding real estate taxes)	613		31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,564		32
33	Accrued Interest Payable	886		33
34	Deferred Compensation	4,489		34
35	Federal and State Income Taxes	3,136		35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 124,711	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	221,359		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 221,359	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 346,070	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,164,524	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 1,510,594	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ 1,120,905</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ 1,120,905</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>202,460</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(158,841)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 43,619</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 1,164,524</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

Facility Name &amp; ID Number Bohannon Nursing Home

# 0016964

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 2,163,626	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,163,626	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,525	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 6,525	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	9,158	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	5,953	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 15,111	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	54,325	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 54,325	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Commissions</b>	385	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 385	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,239,972	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	501,493	31
32	Health Care	882,755	32
33	General Administration	400,642	33
	<b>B. Capital Expense</b>		
34	Ownership	155,239	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	38,950	35
36	Provider Participation Fee	55,297	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,034,376	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	205,596	41
42	<b>Income Taxes</b>	(3,136)	42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 202,460	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name &amp; ID Number Bohannon Nursing Home

# 0016964

Report Period Beginning: 01/01/2001

Ending:

12/31/2001

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,840	2,080	\$ 43,212	\$ 20.78	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,813	4,060	74,739	18.41	3
4	Licensed Practical Nurses	14,361	14,916	225,081	15.09	4
5	Nurse Aides & Orderlies	42,754	44,843	393,128	8.77	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,102	2,270	25,452	11.21	8
9	Activity Director	1,888	2,080	19,579	9.41	9
10	Activity Assistants	1,120	1,140	6,781	5.95	10
11	Social Service Workers	1,312	1,376	14,777	10.74	11
12	Dietician					12
13	Food Service Supervisor	1,904	2,080	22,418	10.78	13
14	Head Cook	4,292	4,701	38,513	8.19	14
15	Cook Helpers/Assistants	9,953	10,401	69,205	6.65	15
16	Dishwashers					16
17	Maintenance Workers	1,737	1,777	20,656	11.62	17
18	Housekeepers	10,701	11,084	87,698	7.91	18
19	Laundry	4,884	5,009	35,702	7.13	19
20	Administrator	1,952	2,080	65,271	31.38	20
21	Assistant Administrator	1,248	1,248	22,688	18.18	21
22	Other Administrative					22
23	Office Manager	1,795	2,075	23,065	11.12	23
24	Clerical	1,295	1,398	12,868	9.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,729	1,992	18,498	9.29	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	110,680	116,610	\$ 1,219,331 *	\$ 10.46	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	128	\$ 4,746	Ln 1, Col 3	35
36	Medical Director	12	3,300	Ln 9, Col 3	36
37	Medical Records Consultant	14	420	Ln 10, Col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	1,010	Ln 10, Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	4	270	Ln 10a, Col 3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	25	1,138	Ln 11, Col 3	44
45	Social Service Consultant	32	1,457	Ln 12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	263	\$ 12,341		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	62	1,641	Ln 10, Col 3	51
52	Nurse Aides	1,277	11,169	Ln 10, Col 3	52
53	TOTAL (lines 50 - 52)	1,339	\$ 12,810		53

## **XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description		Amount	Description		Amount	
Ken Bohannon	Asst. Administrator	100	\$ 22,688	Workers' Compensation Insurance		\$ 28,338	IDPH License Fee		\$ 400	
Lee Bohannon-Smith	Administrator	0	65,271	Unemployment Compensation Insurance		9,795	Advertising: Employee Recruitment		3,578	
				FICA Taxes		91,179	Health Care Worker Background Check		144	
				Employee Health Insurance		10,521	(Indicate # of checks performed 12 )			
				Employee Meals		830	IHCA Dues		4,035	
				Illinois Municipal Retirement Fund (IMRF)*			Sam's Wholesale Club		95	
				Retirement Plan Expense		2,351	NFIB Dues		300	
				Employee Life Insurance		1,109	INHAA		150	
				Less: Employee Insurance		(11,630)	Advertising		3,510	
				Employee Meals		(830)	Attached Schedule		(663)	
							Less: Public Relations Expense	(		
							Non-allowable advertising		(3,510)	
							Yellow page advertising	(		
TOTAL (agree to Schedule V, line 17, col. 1)							TOTAL (agree to Sch. V,		\$ 8,039	
(List each licensed administrator separately.)			\$ 87,959	line 22, col.8)		\$ 131,663	line 20, col. 8)			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount	Description		Amount	
			\$			\$	Out-of-State Travel	\$		
							In-State Travel		2,086	
TOTAL (agree to Schedule V, line 17, col. 3)			\$				Seminar Expense		1,780	
(Attach a copy of any management service agreement)							Administrative Travel		(1,873)	
C. Professional Services							Entertainment Expense	(		
Vendor/Payee	Type		Amount				(agree to Sch. V,			
ADP	Payroll		\$ 6,307				line 24, col. 8)			
Boyce, Hund & Assoc.	Accounting		9,545				TOTAL	\$	1,993	
MES of Illinois	Purchasing		23							
Altschuler, Melvoin & Glasser	Accounting		3,325							
American Express	Accounting		391							
Ron Harvey	Marketing		43,200							
Barkau & Unverfehrt	Legal		195							
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$				
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 62,986							

\* Attach copy of IMRF notifications

**\*\*See instructions.**



## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA = 4,035 - 894 (Nonallowable) = 3,141
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 14
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,457 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. \_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 55,297  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
d. Have vehicle usage logs been maintained? No  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

BOHANNON NURSING HOME, INC.  
FACILITY NO. 0016964  
YEAR ENDED 12/31/01

Schedule V, Page 3, Line 27 - Other General Administrative Expenses

Airplane Expenses	\$2,307	
Contributions	212	
Officer's Life Insurance	3,297	
	<u>\$5,816</u>	

Schedule V, Page 4, Line 42 - Other Special Cost Centers

Bad Debts	\$2,905	
	<u>\$2,905</u>	

Schedule XXV, Page 18, Line 28 - Interest and Other Investment Income

Restricted Funds		\$1,411
Interest		
Unrestricted Funds		
Interest	\$361	
Dividends	23,114	
Capital Gains	29,438	
		<u>\$52,913</u>
Total Interest & Other Investment Income		<u>\$54,324</u>

BOHANNON NURSING HOME, INC.  
FACILITY NO. 0016964  
YEAR ENDED 12/31/01

Schedule XXV, Page 18, Line 41 - Income (Loss) to Federal Income Tax Return  
Form 1120S

Income (Loss) (Page 18, Line 41)		\$205,596
Add:		
Officer's life insurance	\$3,297	
Contributions	212	
Nondeductible dues	1,194	
Soc. 179 expense	14,863	
		<u>19,566</u>
Subtract:		
Investment income	-64,325	
State income tax	-3,136	
		<u>-67,461</u>
Taxable Income (Loss) (Form 1120S)		<u>\$137,691</u>

Schedule XIX, Page 21 - Support Schedules

D. Retirement Plan Expense		
Ken Bohannon	\$330	
Lee Bohannon - Smith	454	
Other Employees	1,567	
	<u>\$2,351</u>	

BOHANNON NURSING HOME, INC.  
FACILITY NO. 0016964  
YEAR ENDED 12/31/01

Schedule XIX, Page 21, - Support Schedules

F. Dues, Fees, Subscriptions and Reg. of Fed. Regulations	\$200	
Social Services Dues	59	
Secretary of State	20	
City of Lebanon	45	
Code Book Update & Newsletters	207	
Non-allowable Dues	1,194	
	<u>\$(963)</u>	